State Veterans' Homes (SVH) Corrective Action Plan
(Hastings Domiciliary Survey 1.18.23 to 1.19.23)

Important: Attestation by the SVH leadership, including the SVH nurse leader, of actions to assure timely completion of goals and establishment of oversight to assure continued improvement in areas identified for correction. The Corrective Action Plan (CAP) should include input from all levels of staff and effected resident(s), as is applicable and appropriate, impacted by the issue identified. This CAP is intended to become a source towards Quality Assurance/Performance Improvement activities (QAPI).

State the Issue **Identify the Standard and Findings**	**Address how corrective action will be accomplished for those residents found to be affected by the deficient practice** (Actions should align with QAPI fundamentals)	**Address how the SVH will identify other residents having the potential to be affected by the same deficient practice**	**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**	**How does the SVH plan to monitor its performance to make sure that solutions are sustained** (Actions should align with QAPI)	**Proposed Completion Date**
§ 51.210 (o) (1) **Clinical records.** The facility management must maintain clinical records each resident in accordance with accepted professional standar and practices . Description findings: Facility failed to maintain complete clinical records for each resident by failing to document COVID – 19 testing results in each resident's medical record. No policy was produced at time of survey for process of ensuring laboratory studies were documented in medical record.	An immediate audit was completed on 100% of resident's charts by the Director of Nursing to ensure documentation of COVID testing done by nursing is recorded in the progress notes within the EMR. This procedure follows the MDVA policy: Critical Test Results Identification and Notification to Provider # HC – 082. The EMR had a progress note with COVID – 19 results, the 'lab results' tab in EMR is only used for contracted company labs, COVID antigen tests are documented in progress note. No other residents effected by this deficit. Completed 3-6-23 <u>Correction Action Plan:</u> The facility reviewed the EMR and noted the diagnosis of COVID – 19 weren't all updated in the	Correction Action will be taken to ensure facility lab results under the CLIA Waiver are documented in all resident's electronic medical record and that the ICD-10 diagnosis code for Covid positive results is added within 3 working days of receipt of results	1. Results will continue to be documented in EMR for COIVD test results. Facility run laboratory results are documented in the progress notes. If a laboratory test is sent to the contracted laboratory, the result will be entered under the Laboratory Results tab in EMR. 2. All nurses will review Policy #HC-082 "Critical Test Results Identification and Notification to Provider." 3. Health Information will update diagnosis list in EMR with current diagnosis within 3 working days of a positive result. When a	1. Health Information will audit COVID positive charts for documentation in EMR progress notes of COIVD test results. Health Information will also audit for ICD-10 COVID diagnosis added to the resident's current diagnoses for positive results. Audits and necessary corrections will occur by 5/31/23 and then will occur monthly. Results will be reported monthly at QAPI for a 100% compliance for May, June, July months to monitor its performance to make sure that solutions are sustained. 2. Sign an 'attestation' for nurses who reviewed the policy "Critical Test Results Identification and Notification to Provider." 3. Health Information will report at QAPI in May, June, and July if a positive diagnosis of COVID was added to EMR within 3 working	1. Health Information (HIM) will only audit COVID positive charts and report to QAPI the months of May, June, and July. 2. DON will report to QAPI 100% compliance with signed attestation forms by June 30, 2023. 3. Health Information (HIM Dept) will report at monthly QAPI if a positive diagnosis of COVID May, June, and July

	'diagnosis' tab of EMR. .		diagnosis of COVID was not entered timely, it will be entered as historical.	days or not.	
§ 51.300 (o) (1) Notice of rights and services – notification of changes Facility management must immediately inform the resident and consult the primary care physician when there is (i) an accident involving the resident that results in injury and has potential for requiring physician intervention; (ii) a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); (iii) a need to alter treatment significantly)i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (iv) A decision to transfer or discharge the resident from the facility as specified in paragraph (d) of this section.	Correction Action will be taken to ensure immediate notification of medical provider of a resident's change of condition <u>Correction Action Plan:</u> An audit was completed on resident's charts to ensure immediate notification of medical provider of any resident's change of condition. No other residents effected by this deficit. Completed 3-6-23	Correction Action will be taken to ensure all residents will have immediate notification to their medical provider of a change of condition	1. All nurses will review Policy #HC-062 "Notification of Resident Changes" to ensure knowledge of policy. 2. Progress notes for the last 24 hours will be audited at least 5 out 7 days a week to ensure immediate notification of medical provider of change of condition to assess skills and ability of reporting change of condition. This will identify other residents having the potential to be affected by the same deficient practice. 3. All nurses be educated on Lippincott "Change of condition: recognizing and responding" to ensure that the deficient practice will not recur.	1. Sign an 'attestation' for nurses who reviewed the policy. Results will be reported monthly at QAPI until at 100% compliance for 3 months. 2. Audit of progress notes will be reported at QAPI for 3 consecutive months to monitor nurse's performance in documentation for notification of change in condition to make sure this process is sustained. 3. Sign an 'attestation' for nurses who reviewed the Lippincott "Change of condition: recognizing and responding". Results will be reported monthly at QAPI until at 100% compliance for 3 consecutive months. 4. To ensure systematic improvements there will be a daily audit of 'Weights and vital portal' this will be reported at QAPI for 3 weeks to monitor its performance to make sure that this process is sustained.	1. Signed attestations will be done by June 30th 2023 2. Progress note audit will be completed by August 30th 2023 3. Signed attestations will be done by June 30th 2023 4. 'Weights and Vitals' audit will be completed by June 31st, 2023

Description findings: Based on interviews and record review, the facility failed to notify the medical provider of a change in condition for one (1) of the three (3) residents (Resident #1) reviewed for changes in condition from total of 11 sampled residents.			4. Once a day the 'Officer of Day' will review the "Weight and Vital Portal' in the EMR for levels that exceed the resident's baseline vital signs. Levels that exceed baseline will be reviewed with primary care provider.		
51.300 (g) (1) Social services. The State home must provide social work services to meet the social and emotional needs of residents to attain or maintain the highest practicable mental and psychosocial well-being of each resident. Description findings: Based on observations and interviews, the facility failed to provide services for one (1) of one (1) resident (Resident #4) who had loud outbursts and did not consider themselves a Veteran like other residents at the facility.	Correction Action will be taken to ensure the social worker services will meet the social and emotional needs of all the residents by completion of 'Trauma Informed Care' assessment on all residents in facility. By completion of this assessment of each resident we seek to: A. realize the widespread impact of trauma and understand path to recovery B. recognize the sign and symptoms of trauma in residents, integrate knowledge about trauma into policy, procedure, and practice C. actively avoid re-traumatization <u>The Corrective Action completed by 3/31/2023 for affected resident is</u>: A. Staff will continue to meet with veteran to offer him coping skills to assist with his behaviors every two weeks. B. A trauma informed care assessment will be	1. All veterans will have a Trauma Informed Care assessment on admission and at a change of condition, care plans will reflect veteran's goals and interventions as well as triggers or situations to avoid 2. All veterans will continue to be encouraged to talk to their care team regarding concerns and issues they might be having. 3. All Veterans will be offered a Grievance to fill out if they feel their needs and concerns need to be addressed. 4. The Security Guard does hourly rounds in the building to Security guard does rounds in building 25 to monitor for any behaviors and contacts staff immediately to intervene there are behaviors or	1. Trauma informed care assessment completed by Social Worker on new resident admission and as needed to promote a culture of safety, empowerment, and healing. 2. Social Services and Behavioral Health will be trained to do Trauma Informed Care assessments to ensure a systematic change is made in completion of assessments in EMR 3. All staff will have Mental Health First Aide training 4. Psychologist to provide education to nursing staff on ways to assist the veteran with maintaining his behaviors such as asking him to take a walk or writing down/journaling. He is encouraged to take his PRN medication when	1. The trauma informed care assessment and care plan focus will be audited by the Health Information staff to ensure it is completed on each Veteran by 5-31-23. Results will be reported monthly at QAPI for 3 consecutive months on documentation in EMR of veteran's goals and interventions as well as triggers or situations to avoid to monitor staff skills and abilities to assess for possible re-traumatization. This will be reported monthly in QAPI meetings by the Social Worker Supervisor to make ensure that solutions are sustained. 2. Education on Trauma Informed Care Assessments will be provided, and employee will sign an 'attestation' form for completion of education by 4/30/23. 3. Continue to maintain 100% of employees will be trained on Mental Health First Aid (MHFA). We will continue to offer the ASSIST training to staff who complete MHSA. A process will be put into place for tracking employees MHFA training and ASSIST training.	1. Audit by August 31, 2023 2. Audit by August 3`, 2023 3. Supervisors and employee will continue to submit their training sheets from Mental Health First Aide, this will be given to Human Resource to keep all training records for employees in their Education File 4. Clinical Standup documentation tool will reflect documentation of behaviors or complaints/grievances-SW or designee to Audit weekly for one month and then monthly for 3 months.

	completed on this veteran to assist him with meeting his needs. C. Staff will continue to document behavioral veteran's outburst and behaviors. D. Veteran will be offered non virtual mental health appointments to assist him with his behaviors including facility psychologist as well as private pay options E.The affected Veterans who initially lodged the complaints were met with and offered noise cancelling devices, sound machines, and alternative placement to another room on the campus. They were asked about their current needs, offered support, and instructed to call nursing or use the call light with any concerns or issues and staff will promptly address the concerns in person. They were reminded to also bring their concerns to the social worker. F. The resident expressing himself loudly during the night has agreed to respect the quiet time of his neighbors. G. Staff were taught how to intervene and assist the resident if he becomes disruptive by the psychologist. A Behavior Tracking Log was started	safety concerns	he is having behaviors. Staff is to approach the veteran and asked how he is doing and if they can assist him when he is yelling. The interventions have been also placed in his care plan. A Behavior Log has been started	4. Behavior Log, and any complaints or grievances from other residents will be addressed at weekly clinical team meetings which will help staff determine if alternative action needs to be taken	
51.350 Life Safety Fire K-type fire extinguisher placard	Corrective Action completed, to meet the applicable requirements of the National Fire Protection Association's	The required placard for K-type fire extinguisher will remain in place.	1. Work Order completed 2. The required placard for K-type fire extinguisher will remain	The required placard for K-type fire extinguisher will remain in place. Physical Plant Director will monitor 1	Repair completed 1/31/2023 Complete Audit by July 31, 2023

The findings include: Based on observations and interview, the facility failed to install the required placard for K-type fire extinguisher. The deficient practice one (1) of 11 smoke compartments in Building 23,staff, and no residents. The facility had the capacity for 200 beds with a census of 110 on the day of survey.	NFPA 101, Life Safety Code, the required placard for K-type fire extinguisher has been put in place.		in place. 3. Photo of repair	time a month for the months of May, June, and July and report to QAPI the required placard for K-type fire extinguisher is remaining in place to ensure that solutions are sustained.	
51.350 Life Safety Fire Gas equipment restraint system install. The findings include: Based on observation and interview, the facility failed to properly install gas equipment and appliances. The deficient practice one (1) of 11 smoke compartments in Building 23 staff, and no residents. The facility had the capacity for 200 beds with a census of 110 on the day of survey.	Corrective Action completed, to meet the applicable requirements of the National Fire Protection Association's NFPA 101, Life Safety Code, the proper gas equipment and appliances have been installed.	The proper gas equipment and appliances have been installed.	1. Work Order completed 2. The proper gas equipment and appliances have been installed. 3. Photo of repair	The proper gas equipment and appliances will remain in place Physical Plant Director will monitor 1 time a month for the months of May, June, and July and report to QAPI the proper gas equipment and appliances have remain in place to ensure that solutions are sustained.	Repair completed 1/31/2023 Complete Audit by July 31, 2023
51.350 Life Safety Fire Emergency generators remote e-stop for each generator. The findings include: Observation during the building inspection tour, on 1/18/23, at 10:05 a.m., revealed the facility's emergency generator was not provided with a remote, manual stop station for each generator located elsewhere on the premises, as	Corrective Action completed, to meet the applicable requirements of the National Fire Protection Association's NFPA 101, Life Safety Code	The Emergency generators remote e-stop for each generator	1. Work Order completed 2. Emergency generators remote e-stop for each generator have been installed 3. Photo of repair	Emergency generators remote e-stop for each generator will remain in place Physical Plant Director will monitor 1 time a month for the months of May, June, and July and report to QAPI Emergency generators remote e-stop for each generator are in place to ensure that solutions are sustained.	Installation Completed 3/14/23 Complete Audit by July 31, 2023

required by sections 5.6.5.6 and 5.6.5.6.1 of NFPA 110, Standard for Emergency and Standby Power Systems. Additional observation, on 1/18/23, at 10:05 a.m., revealed there was only one remote, manual stop button for the two generators installed at the facility.					
51.350 Life Safety Fire Generator annunciator panel inoperable. The findings include: Based on observation and interview, the facility failed to provide essential electric system alarm annunciators for the onsite generators. The deficient practice affected 23 of 23 smoke compartments, staff, and 110 residents. The facility had a capacity for 200 beds with a census of 110 on the day of the survey.	Corrective Action completed, to meet the applicable requirements of the National Fire Protection Association's NFPA 101, Life Safety Code	Generator annunciator panel inoperable been repaired.	1. Work Order completed 2. Generator annunciator panel inoperable has been repaired. 3. Photo of repair	The Generator annunciator panel will immediately be repaired if inoperable. Physical Plant Director will monitor 1 time a month for the months of May, June, and July and report to QAPI the Generator annunciator panel operable.	Repair completed 1/20/23 Complete Audit by July 31, 2023

- This Corrective Action Plan is to be sent to the Medical Center Director of jurisdiction and VACO Pod Manager